ivira specialty pharmacy

Neurology Referral Form

Please fax completed referral form to ivira:
(302) 499-8729
Please contact office for questions:
(302) 499-8727

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PREFERRED CONTACT #:
DATE OF REFERRAL:	GENDER: ☐ F ☐ M
SOCIAL SECURITY NUMBER:	ADDRESS:
DATE OF BIRTH:	CITY, STATE, ZIP:

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

☐ G35 - Multiple Sclerosis ☐ OTHER: _____

REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

☐ 1. INSURANCE CARD (Front & Back) ☐ 2. PATIENT DEMOGRAPHICS ☐ 3. MOST RECECNT LABS ☐ 4. H & P

MEDICATION SELECTION:

AUBAGIO® (teriflunomid)	☐ TAKE 7 MG ONCE DAILY ☐ TAKE 14 MG ONCE DAILY REFILLS:_____
AVONEX® (interferón beta-1a)	**TITRATION DOSE:** ☐ INJECT 7.5 MG ONCE WEEKLY, THEN 15 MG ONCE ON WEEK 2, 22.5 MG ONCE ON WEEK 3, & 30 MG ONCE ON WEEK 4 **MAINTENANCE:** ☐ INJECT 30 MG IM ONCE WEEKLY REFILLS:_____
BETASERON® (INTERFERON BETA-1b) FOR SC INJECTION	**TITRATION DOSE:** ☐ INJECT 0.0625 MG EVERY OTHER DAY FOR 2 WEEKS, THEN 0.125 MG EOD FOR 2 WEEKS,THEN 0.187 MG EOD FOR 2 WEEKS, THEN 0.25 MG EVERY OTHER DAY **MAINTENANCE:** ☐ INJECT 0.25 MG SC EVERY OTHER DAY REFILLS:_____
COPAXONE® (glatiramer acetate injection)	☐ INJECT 20 MG SC DAILY ☐ INJECT 40 MG SC THREE TIMES PER WEEK, ADMINISTERED AT LEAST 48 HOURS APART REFILLS:_____
EXTAVIA® interferon beta-1b FOR SC INJECTION	**TITRATION DOSE:** ☐ INJECT 0.0625 MG EVERY OTHER DAY FOR 2 WEEKS, THEN 0.125 MG EOD FOR 2 WEEKS,THEN 0.187 MG EOD FOR 2 WEEKS, THEN 0.25 MG EVERY OTHER DAY **MAINTENANCE:** ☐ INJECT 0.25 MG SC EVERY OTHER DAY REFILLS:_____
GILENYA® (fingolimod)	☐ TAKE 0.5 MG BY MOUTH DAILY REFILLS:_____
Rebif® (interferon beta-1a)	**TITRATION DOSE:** ☐ INJECT 8.8 MCG SC 3X/WEEK x 2 WEEKS, THEN 22 MCG SC 3X/WEEK x 2 WEEKS **MAINTENANCE:** ☐ INJECT 22 MCG SC THREE TIMES PER WEEK ☐ INJECT 44 MCG SC THREE TIMES PER WEEK REFILLS:_____
Tecfidera® (dimethyl fumarate) delayed-release capsules 240 mg	☐ TAKE 120 MG BY MOUTH TWICE DAILY ☐ TAKE 120 MG BID FOR 7 DAYS; THEN 240 MG TWICE DAILY ☐ TAKE 240 MG BY MOUTH TWICE DAILY REFILLS:_____

PRESCRIBER INFORMATION:

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	LICENSE #:
CITY, STATE, ZIP:	NPI:

PHYSICIAN SIGNATURE: DATE:

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby vauthorize Ivira Health and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature. NEURO V1 081020